Developing an effective electronic social care record for care in the home

Cooper, Janet; Urquhart, Christine

Publication date:
2005

Citation for published version (APA):
Cooper, J., & Urquhart, C. (2005). *Developing an effective electronic social care record for care in the home*. 21-23. http://hdl.handle.net/2160/210

Developing an effective electronic social care record for care in the home

J. Cooper[1], C. Urquhart[2]
[1] 6 Mayfield Avenue, Victoria Park, Cardiff CF5 1AN
[2] Department of Information Studies, University of Wales Aberystwyth, SY23 3AS,
cju@aber.ac.uk, tel. 01970-622162

Abstract

This paper explores implications for the development of an electronic social care record (ESCR). Six homecare settings were studied over 14 months between 2001 and 2002. Participant observation methods were used with the recipients of homecare (n=7) and in-depth interviews plus participant observation with formal care workers (n=31). Allied healthcare professionals (n=9) and homecare managers (n=5) were interviewed, as were 2 family members. The findings show that effective delivery and receipt of homecare depends upon an efficient and timely flow of factual information, and often tacit knowledge, between the homecare setting, care managers and other interested professionals. In reality, vital tacit knowledge is difficult to express and often not perceived as important by the knowledge holder. In addition, care workers often selectively withhold information from care managers and others. Obvious implications for the development of an ESCR are that key information and knowledge will be omitted from the record.

Keywords: Home care services; Social work; Medical records systems, computerized

Introduction

The last decade and a half has witnessed a shift towards community-based health and social care, but at the same time, increasing numbers of older people with multiple health conditions and complex social care needs. One outcome of these changes is the growing importance of homecare, wherein formal care workers deliver social and personal care in a client's home. Social care provision costs the DoH £9 billion per year[1], with over one million adults and older people receiving social care support each week[2].Quality of care delivery and efficient management of homecare provision rely upon the efficient and timely recording and exchange of information. This paper traces the paths of information collection in homecare delivery, based on research to identify the information flows between the recipients and providers of homecare. The methods used were participant observation and in-depth interviews. This paper discusses the qualitative research findings that show the sometimes erratic flow of information between care staff, the reasons for some of the observed problems, and concludes by considering the implications for development of an electronic social care record (ESCR).

Literature review

Homecare settings are difficult areas to access for researchers and there has been limited in-depth research to date. The overall picture is one of very poor communication between health and social care providers[3] [4] [5]. Information for Social Care [6] established principles for information management in social care, and the consultation document Defining the Electronic Social Care Record [7] examined how these principles would apply to electronic recording and document management in social care. Implementation has consequences for the National Service Framework for Older People (NSF) proposals for a one-stop single assessment [8]. There are obvious issues of confidentiality for a combined and more widely accessible record in homecare[9]. Exploring the obstacles to joined-up communication and information exchange between social care and healthcare providers [2] identified cultural barriers. These included differences in terminology between health and social care providers, the ways in which staff and organisations think and work and problems surrounding accessibility to information.

Research methods

Overt participant observation and in-depth interviews were used to obtain as true a picture as possible of information flows and information management in homecare. For ethical reasons, these vulnerable care recipients were not interviewed and fieldnotes were recorded offsite. Care recipients were thus observed but not interviewed. The researcher performed dual roles as care worker and fieldworker, ensuring access to the setting, building of trust and eventual acceptance by study participants. Triangulation was achieved through verification of findings from observations, casual conversations and interview responses. Overall, six settings involving seven clients were observed over an 18 month period, and 31 care workers, 2 family members, 5 care managers and 9 allied

professionals were interviewed. Sampling was largely purposive. The qualitative software package, NVivo was used to code and analyse the data.

Findings

The findings presented here focus on the information flows and processes used to create and maintain information about a client.

Establishing a care package

In the first instance, information is collected by a homecare manager or social worker from the new client (or their advocate) and transferred to the local authority or private agency's information management system. Care managers cannot always obtain a true picture of a client setting:

> 'Now what was a crisis on day one, when I go and visit on day two Mrs So-and-so is sitting there fully clothed - she hasn't been dressed for six months - fully clothed, make up on, "tea dear?" They try and present a different picture to us…' (Care Manager3)

Large proportions (up to 70%) of LA (Local Authority) care packages created on the basis of this information change within the first few weeks after implementation. Comments from the private sector indicate that care packages also change at an early stage:

> '…because a lot of the information that the social worker has and the care-plan that's set up isn't really what's needed. Or, what they feel they need, they may feel that person needs washing and dressing, whatever…, the client themselves, "no, I can wash and dress, but I need help in other areas." ' (Other Care Worker3)

When asked about information supplied by care managers this care worker responded:

> 'None! Or, on some occasions the wrong information.' (Other Care Worker2)

A LA care worker noted how care workers were relied upon for information and conducted their own assessments to identify clients' needs:

> '…they phone you and say we have a new referral for you, "uh it's Mr So-and-so or Mrs So-and-so, blah, blah um just tell you roughly what to do, "uh can you get back to me, tell me how you get on". And then you go in and you assess the situation yourself' (Local Authority Care Worker1)

Other care workers were much more positive, but the dissemination of information is heavily dependent on the motivation of the particular care manager:

> '…I keep mentioning (*name of care manager*) 'cos she is the best there.' (Care Worker30)

Access to information

Only a tightly prescribed range of people who have some input into a client's care can access client information systems. For example, private sector on-call managers did not have full access to client records. This on-call manager had only partial access during out-of-hours periods when fully-fledged managers were reluctant to provide support to the on-call manager:

> 'I always felt I was useful, but not of… the inner sanctum, you know.' (Care Worker23)

On-call managers relied on personal relationships with particular care workers to glean 'local' client information from them, which was often urgently required. Partial access to the information system was blamed on the lack of trust and issues of client confidentiality. Access is a two way process and it will be seen next how care managers were in-turn, excluded from, information.

Information gatekeepers

The findings of this study show how care workers become the ultimate information gatekeepers who filtered information selectively to care managers whose task was to create and maintain existing clients' social care records. Care workers' primary motives were to protect the privacy of the client:

> 'You don't want to be telling them (*care managers*) every little detail. Whereas we would tell each other (*care workers*) to look out for this, or the client may have difficulty there… little personal things that you don't want to be unkind about, but you need to perhaps, tell each other about.' (Care Worker20)

The researcher observed that private sector care workers often took full responsibility for a client's problems and perceived it unnecessary for care managers to be involved in a particular situation. The impacts of not passing on the information may not be felt until a new care worker is sent into the setting inadequately informed because the care manager had not been appraised of changes to a client's personal details by the existing care workers. In the State sector information sharing is heavily promoted through care worker / care manager monthly meetings and the provision of mobile telephones to care workers. Care workers must also log-in to, and log-off from, care sessions with a care co-ordinator. Care worker / care manager meetings had been abandoned by the private sector agencies surveyed, and no logging-in was required. Care managers did, however, have daily contact with client situations where there were significant problems.

Rapid change

Client situations can change rapidly (as seen in Care Manager3's comment above) and any change needs to be immediately reflected in the client record. Last minute discharges from hospital, emergency admissions, changes to a client's health status, or a care worker's crisis must be relayed to care managers quickly for them to act upon the information. In practice, this did not always happen and care managers were not always updated. There were frequent problems between care managers and social workers with regard to a lack of communication and information exchange. Care managers complained that some social workers were difficult to contact:

'to get hold of a social worker is almost impossible'. (Care Manager3)

Family members reiterated this point and some social workers also claimed that it was difficult to communicate with their colleagues.

The nature of the information

The nature of some key client information makes it difficult to express and record. Knowledge and information held by care workers is often tacit in nature. Care workers were unable to articulate their knowledge about a client: 'I just know' or 'you know' were common responses to questions about a care worker's knowledge. One attempted to explain her mechanism for interpreting client needs:

> '… only by observation can you know… right paracetamol, uh fybogel, lactulose, coffee, squash.' (Care Worker1)

The researcher's fieldnotes revealed her tacit knowledge and the difficulties of sharing it with others:

> 'I tried to show Care Worker24 without CL1 (*a client*) in the harness and it seemed to me a very logical and simple to use piece of kit…' (Observation notes)

In reality, it took many months of close working with Care Worker24 and the harness before she become competent with it and handling the client. Over time with a client individual care workers build up a vast repository of client information that is not always formally recorded: 'I have got it all in my head.' (Care Worker4) Some used a 'mental checklist' to deal with what they need to know. Care managers expect care workers to assume the role of a detective, seeking missing bits of information to fill the gaps after their initial assessment or recognising changes in the client situation. Care workers interpret and recognise non-verbal signs indicating a client's need or mood, which aids their handling of a client or situation. These vital pieces of knowledge are not recognised by the care worker until they are asked for a particular piece of information. As seen above the information often remains within the care setting or between certain care workers. The information that care managers have to work with will be at best, incomplete. If ‘one of the key issues in social care recording is what information was known at a specific point in time that informed the decisions that were made then, and to record those decisions and service provisions’ [10] then clearly time points have to be agreed to assess whether changes have in fact taken place. Old and /or partial

information can become dangerous information for which care managers cited examples where clients' safety was jeopardised.

Resistance to electronic information?

Care managers and care workers alike distrusted electronic information. Care managers and social workers in the LA had negative experiences of a client information system that was often 'down' and had limited capability. They also lacked formal training in the use of electronic information systems and the LA depended on the cascading of training by one or two people with informal interests in IT. Older-aged care managers in the private sector were wary of electronic information and had limited IT skills, and they too depended on informal training. Care workers showed distress when the word computer was mentioned yet several stated they shopped via the Internet and were often observed text messaging on mobile telephones.

Discussion

Existing proposals [10] focus on the need for a care plan to have a minimum content definition (para. 3.10) and indicate the problems of granularity and consent (para 3.6, 3.7). This study suggests that in some homecare settings, where the care teams are well established, homecare staff tend to filter information, to protect client confidentiality, but with the result that vital information may sometimes not reach the formal record. Care planning is a process of negotiation initially. Existing proposals also focus on the concept of the ‘document’ in social care, but more account needs to be taken of existing methods (log books, post-it notes on fridge doors) that were observed as means of sharing information. What is a ‘document’ to a care manager may not be a meaningful way of monitoring care for a homecare worker. Education and training need to take account of the ways in which homecare workers routinely use information and communications technologies.

Conclusions

More research is required on the actual practices of recording and sharing information by different agencies in homecare before proceeding to define the terminology, and standardise practice for an electronic social care record.

References

1. Department of Health. *Modernising Social Services*. London: DoH, 1998.
2. Staton R. Integrating healthcare and socialcare – meeting the challenge. Br J Healthc Comput & Inf Manage 2003;20:18-20.
3. Cawthra L. Older people's health information needs. Health Lib Rev1999;16:97-105.
4. Payne S., Kerr, C., Hawker, S., Hardey, M., Powell J. The communication of information about older people between health and social care practitioners. Age Ageing 2002;31:107-117.
5. The Royal Commission on Long Term Care. *With Respect To Old Age: Long Term Care – Rights And Responsibilities. Alternative Models of Care for Older People. Research Volume 1, The Context of Long-Term Care Policy.* London: The Stationery Office, 1999.
6. Department of Health. *Information for social care.* London: DoH, 2001.
7. Department of Health. *Defiining the electronic social care record. Consultation draft.* London: DoH, June 2003.
8. Firth P. Preparing for healthcare and socialcare integration: some current barriers to ICT-based sharing of information. Br J Healthc Comput & Inf Manage 2003;20:21-24.
9. Cooper J., Urquhart CJ. Confidentiality issues in information systems on social care. In K. Grant, DA. Edgar, M. Jordan. *Reflection on the past, making sense of today and predicting the future of information systems, 9th Annual Conference Proceedings (UKIAS),* Annual Conference 5th-7th May 2004, Glasgow Caledonian University, Glasgow.
10. Department of Health. *Defining the electronic social care record.* London: Department of Health, December 2003, para.3.2